Appendix L-1

Technical Guidelines for Paper Claim Preparation
Form HFS 2211, Laboratory/Portable X-Ray Invoice

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
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- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Instructions for completion of this invoice follow in the order entries appear on the form. Providers may view a HFS 2211 facsimile on the Department's Web site.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

Not Required = Fields not applicable to the provision of laboratory services.

Completion	Item	Explanation and Instructions
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the Provider NPI.
Conditionally Required	**3.**	**Payee** - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
Not Required	4.	Group - Leave blank.
Not Required	5.	Role - Leave blank.

Completion	Item	Explanations and Instructions
Not Required	6.	Acc/Inj - Leave blank.
Optional	**7.**	**Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.
Optional	**8.**	**Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the Department will not attempt corrections.
Conditionally Required	**9.**	**Facility & City Where Service Rendered** - This entry is required when Place of Service Code is other than J (laboratory).
Not Required	10.	Prior Approval - Leave blank.
Optional	**11.**	**Provider City State Zip** - Enter city, state and zip code of provider. See Item 8 above.
Required	**12.**	**Referring Practitioner Name -** Name of physician ordering test.
Required	**13.**	**Ref. Prac. No.** - Enter a unique identifying number (provider #; SSN; UPIN) of the ordering physician.
Required	**14.**	**Recipient Name** - Enter the patient's name exactly as it appears on either the MediPlan Card or Temporary MediPlan Card or All Kids Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Completion	Item	Explanations and Instructions
Required	**15.**	**Recipient No.** - Enter the nine-digit number assigned to the individual as copied from either the MediPlan Card or Temporary MediPlan or All Kids Card. Do *not* use the Case Identification Number. If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.
Optional	**16.**	**Birthdate** - Enter the month, day and year of birth of the patient as shown on either the MediPlan Card or Temporary MediPlan Card or All Kids Card. Use the MMDDYY format.
Not Required	17.	Healthy Kids - Leave blank.
Not Required	18.	Fam Plan - Leave blank.
Not Required	19.	Cr. Child - Leave blank.
Not Required	20.	St/Ab - Leave blank.
Required	**21.**	**Billing Date** - Enter the date the invoice was prepared. Use MMDDYY format.
Required	**22.**	**Primary Diagnosis Description** – Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.
Not Required	23.	Prefix

Completion	Item	Explanation and Instructions
=Required *Effective 10/1/15*	**24.**	**Diag. Code** – Effective with dates of service on and after October 1, 2015, enter the primary diagnosis code exactly as it appears in the ICD-10-CM manual. **This field will contain both the alpha and numeric characters of the diagnosis code.** Do not enter the decimal point.
Not Required	25.	Secondary Diagnosis - Leave blank.
Not Required	26.	Prefix - Leave blank.
Not Required	27.	Diag. Code - Leave blank.
	28.	**Service Sections**: Complete one service section for each item or service provided to the patient.
Required		**Procedure Description** - Enter the appropriate description of the service provided.
Required		**Proc. Code** - Enter the appropriate five-digit procedure code as specified in this handbook.
Conditionally Required		**Delete** - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.
Required		**Date of Service** - Enter the date the service was performed. Use MMDDYY format.
Required		**Cat. Serv.** - Enter 43 to identify laboratory services as the category of service.
Required		**Place of Serv.** - Enter the one letter Place of Service Code from the following list:

Code:	**Place of Service**:
H	Long Term Care Facility
I	Shelter Care
J	Laboratory
K	Patient's Home

Completion	Item	Explanations and Instructions
Conditionally Required		**TPL Code** - If the patient's MediPlan or All Kids Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required. When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields. If Form HFS 2432 shows a recipient liability greater than $0.00, the invoice should be coded as follows: TPL Code 906 TPL Status 01 TPL Amount the actual recipient liability as shown on Form HFS 2432. TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format. If Form HFS 2432 shows a recipient liability of $0.00, the invoice should be coded as follows: TPL Code 906 TPL Status 04 TPL Amount 0 00 TPL Date the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Completion	Item	Explanation and Instructions
Conditionally Required		**Status** - If a TPL code is shown in Item G, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank. The TPL Status Codes are: **01 - TPL Adjudicated - total payment shown**: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received *must* be entered in the TPL amount box. **02 - TPL Adjudicated - patient not covered**: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided. **03 - TPL Adjudicated - services not covered**: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered. **04 - TPL Adjudicated - spenddown met**: TPL status code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability. **05 - Patient not covered**: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force. **06 - Services not covered**: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided. **07 - Third Party Adjudication Pending**: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed. **10 - Deductible not met**: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Completion	Item	Explanation and Instructions
Conditionally Required		**TPL Amount** - If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.
Conditionally Required		**Adjudication Date** - A TPL date is required when any status code is shown in Item 28G. Use the date specified below for the applicable code: **Code Date to be entered** 01 - Third Party Adjudication Date 02 - Third Party Adjudication Date 03 - Third Party Adjudication Date 04 - Date from the HFS 2432 05 - Date of Service 06 - Date of Service 07 - Date of Service 10 - Third Party Adjudication Date
Required		**Provider Charge** - Enter the total charge for the service, not deducting any TPL.
Conditionally Required		**Repeat** - Place X if the service is done on the next date.
Unlabeled		**Charges and Deductions Section** - The information field in the lower right of the HFS 2211 is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources 2) to identify uncoded TPL carriers by name and 3) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in service sections 1 through 7 of the HFS 2211, complete the TPL fields in accordance with the following instructions.

Completion	Item	Explanations and Instructions
Conditionally Required		**Sect. #** - If more than one third party made a payment for a particular service, enter the service section number (1 through 7) in which that service is reported. If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in this section will be applied to the total of all service sections on the invoice.
Conditionally Required		**TPL Code** - Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.
Conditionally Required		**Status** - Enter the appropriate TPL Status Code. See Item 28H in this Appendix for correct coding of this field.
Conditionally Required		**TPL Amount** - Enter the amount of payment received from the third party resource.
Conditionally Required		**Adjudication Date** - Enter the date the claim was adjudicated by the third party resource. (See Item 28J in this Appendix for correct coding of this field.)
Conditionally Required		**Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used. The three claim summary fields must be completed on all Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom right of the form.

Completion	Item	Explanations and Instructions
Required		**Total Charge** - Enter the sum of all charges submitted on the Invoice in service sections 1 through 7.
Required		**Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
Required		**Net Charge** - Enter the difference between Total Charge and Total Deductions fields.
Required	**31.**	**# Sects** - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and not more than 7. Do not count any sections which were deleted.
Not Required	32.	Original DCN - leave blank.
Not Required	33.	Original Voucher Number - leave blank.
Required		**Provider Certification, Signature and Date** -After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date must be entered.

Appendix L-1b

Preparation and Mailing Instructions for Medicare/Medicaid Combination Claims

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Intermediary or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare intermediary on Form HCFA 1500. The words "Illinois Department of Healthcare and Family Services" or "HFS" and the patient's nine-digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare intermediary automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- Payment is made by the Medicare intermediary but the EOMB does not show that the claim has been crossed over, or
- More than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,
- the provider's Provider Number in the lower right hand corner of Field 33, and
- the one-digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare intermediary. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form HFS 2211 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence must also be attached.

Appendix L-2

Explanation of Information On Provider Information Sheet

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date your signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic L-201.2 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix L-2a.

Field	Explanation
Provider Key	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
Provider Name and Location	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.

Field	Explanation
Enrollment Specifics	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative which indicates the provider's classification. **Organization Type** is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are: 01 = Individual Practice 02 = Partnership 03 = Corporation **Enrollment Status** is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are: B = Active I = Inactive N = Non Participating Disregard the term NOCST if it appears in this item. Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field. **Exception Indicator** may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are: A = Exception Requested By Audits C = Citation to Discover Assets G = Garnishment S = Exception Requested By Provider Participation Unit T = Tax Levy If this item is blank, the provider has no exception. Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims are to be manually reviewed and the **END** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank. **AGR** (Agreement) indicates whether the provider has a form HFS 1413 (Provider Agreement) on file. If the value of this field is yes, the provider is eligible to submit claims electronically.

Field	Explanation
Certification/ License Number	This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.
S.S.#	This is the provider's Social Security or FEIN number.
Categories of Service	This area identifies special licensure information and the types of services a provider is enrolled to provide. **Eligibility Category of Service** contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The code is: 043 - Clinical Laboratory Services Each entry is followed by the date that the provider was approved to render services for each category listed.
Payee Information	This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **Payee Code**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid. If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected. **Payee ID Number** is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider. The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.
Signature	The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.